

Table 3. Outcomes among patients hospitalized with mpox

	Overall cohort N=65	Admitted for mpox medical indication N=57	Admitted for mpox isolation N=8	p-value ^a
Total number of hospital admissions	80	72	8	-
Number of hospital admissions per patient, median (IQR)	1 (1-1)	1 (1-1)	1 (1-1)	0.18 ^b
Cumulative length of stay per patient in days, median (IQR)	4 (2-10)	4 (2-10)	6 (3-9)	0.69 ^b
Significant complications				
Secondary bacterial infections	40 (62%)	38 (67%)	2 (25%)	0.02
All-cause ICU admissions ^c	8 (12%)	8 (14%)	0 (0%)	0.26
Cumulative length of stay for patients in ICU (N=8)	4 (2-41)	4 (2-41)	0	N/A ^d
In-hospital death	3 (5%)	3 (5%)	0 (0%)	N/A ^d
Treatments received				
Tecovirimat	40 (62%)	37 (65%)	3 (38%)	0.14
Antibiotics	49 (75%)	47 (82%)	2 (25%)	<.01

^aPearson's chi-squared test, unless otherwise specified.

^bWilcoxon ranked sum test.

^cOf the eight patients admitted to the ICU, five (63%) had an ICU indication (mechanical ventilation, need for pressor support, or need for renal replacement therapy).

^dp-value is N/A due to insufficient number of patients for analysis.

Sixty-five patients were hospitalized for mpox, with 8 (12%) admitted primarily for infection control isolation (Table 1). Median age was 35 years (IQR=31-40), 69% were cisgender men, and 38% were Black. Those hospitalized primarily for isolation were more likely to reside in a homeless shelter (50% vs. 9%, $p < 0.01$) and less likely to have a private residence (25% vs. 81%, $p < 0.01$) than those hospitalized for medical indications. Those hospitalized for medical indications were more likely to have HIV (63% vs. 25%, $p=0.04$), secondary bacterial infections (67% vs. 25%, $p=0.02$), and to receive antibiotics (82% vs. 25%, $p < 0.01$) (Tables 2 and 3). There was no significant difference in median cumulative length of stay per patient ($p=0.69$) between those hospitalized for medical versus isolation purposes. Most admissions for medical indications were for soft tissue superinfection (40%), severe pharyngitis and/or proctitis (28%) and pain management (20%). There was no significant difference in the proportion of tecovirimat receipt (65% vs. 38%, $p=0.14$) between those hospitalized for medical versus isolation purposes. **Conclusion:** Infection control isolation accounted for a significant proportion (12%) of mpox hospitalizations and was associated with a similar median length of stay per patient as hospitalization for medical indications. Our small cohort limits statistical power for comparison between groups. However, our findings argue for increased community-based isolation capacity. This may reduce unnecessary hospitalizations during future outbreaks, particularly amongst unsheltered individuals or those living in congregate settings.

Disclosure: Madeline DiLorenzo: Stocks - Abbvie, Amgen Inc., Becton Dickinson, Biogen Inc., Bristol Myers and Squibb, CVS Health, Davita Inc., Elevance Health, Gilead, Henry Schein, Hologic Inc., Humana Inc., Jazz Pharmaceuticals, Laboratory Corp, Merck and Co., Quest Diagnostics, ResMed Inc., Teladoc Health, Vertex Pharmaceuticals, West Pharmaceuticals

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Presentation Type:

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Subject Category: Emerging Pathogens

Building a Special Pathogen Response Center from the Ground Up

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North Carolina at Chapel Hill and William Fischer, University of North Carolina at Chapel Hill

Background: In September 2022, UNC Hospitals was awarded a Regional Emerging Special Pathogens Treatment Center (RESPTC) grant by the U.S. Department of Health and Human Services Administration for Strategic Preparedness and Response (ASPR) to care for up to two patients with viral hemorrhagic fever, or similar pathogen, and up to ten patients with novel respiratory pathogens. Intensive infection prevention efforts and timely multidisciplinary commitment was required to develop the Space, Strategy, Staff, and Stuff needed to care for patients with a special pathogen. **Methods:** Multiple space needs assessments were undertaken to acquire spaces for the care of patients, simulation training, and a dedicated laboratory. Strategies for developing the response plan required collaboration with hospital executives, nursing leadership, public health leaders, and regional partners. Staff were recruited across various disciplines to join the response team and were provided hands-on skills training which was assessed by post-training surveys. Specialized 'stuff' (i.e., PPE, training equipment, and waste management devices) were researched and procured for use by the team. **Results:** Patient care and dedicated laboratory space was identified within existing infrastructure, and renovation plans were developed to adapt the space for these specialized activities. A waste management plan that benefits the hospital for routine waste and allows for Category A waste management was approved. Fifty-three staff members were recruited from 3 main disciplines (RNs, MDs, Paramedics), and across numerous settings (Medicine Acute Care & ICU, Pediatric ICU & Stepdown, Air Care/Transport, Burn ICU, Surgery Stepdown, Emergency Medicine, Infection Prevention, Infectious Disease) were trained during five 4-hour training sessions, culminating in an exercise involving transporting a rule-out Ebola patient to the hospital's special pathogens unit. Post-training evaluations demonstrated a very high level of confidence ('strongly agree') in staffs' knowledge about the RESPTC site (92.3%), special pathogens (80.8%), collaboration needed for managing patient care (80.8%), and in their comfort with special PPE donning and doffing (73.1%). **Conclusions:** Using a systematic approach to develop Space, Strategy, Staff, and Stuff, a large academic hospital readied itself to become a new RESPTC site. Key lessons learned include the importance of a multidisciplinary response team; local, state, and regional coordination for care planning and delivery; and early community partnership development. Logistical infrastructure and waste management challenges continue to require partnership with hospital leadership to optimize workflows and patient care. Holistic decision-making around infrastructure has led to changes that benefit all hospital patients and offer efficiencies to

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Improving Cleaning Validation Utilizing Adenosine Triphosphate Technology

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Background: Thorough cleaning and disinfection of high-touch surface areas in hospital inpatient rooms remain vital parts of effective strategies in reducing hospital-acquired infections (HAIs). Currently, Methodist Specialty & Transplant Hospital (MHST) inconsistently utilizes fluorescent marking for terminal cleaning validation. Without quantitative results, it's difficult to measure the effectiveness of cleaning. To ensure